

12292

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 5 $\frac{1}{2}$ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tibbitt Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William James		First Middle Last Adams	4. DATE OF DEATH December Month Day 31 Year 1956
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME William James Adams.	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Wm. Willis.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Address Easton, Md.	
DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		Aug. 5, 1951, to Dec. 31, 1956, that I last saw the deceased alive on Dec. 30, 1956, and that death occurred at 7:30 P.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.		ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 12/31/56	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 3, 56	
22b. DATE THEREOF Jan 3, 56		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill	
22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Ladd		24a. REC'D BY REGISTRAR JAN 4 1957	24b. REGISTRAR'S SIGNATURE J. Mae Pippin
ADDRESS Baltimore Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
**12293**

12275  
64

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Houston Branch Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
3. NAME OF DECEASED (Type or print) Roy		First Middle Scott	Last Anderson
4. DATE OF DEATH December 5	Month Year 1956	5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED WIDOWED	NEVER MARRIED Unknown	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) About 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Marion Station, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Bertha Dashields, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE DAWSON O. GEORGE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 14/5/56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 10, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery	22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Dec. 10, 1956	24b. REGISTRAR'S SIGNATURE Margaret H. Frampton

BUREAU V.

DEC 28 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12294

## CERTIFICATE OF DEATH

12276

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b 71 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bridgeville Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural	
d. STREET ADDRESS Bridgeville Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Alfred	Last Fishell
4. DATE OF DEATH	Month December	Day 31	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1881
9. AGE (In years less birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos L. Fishell		14. MOTHER'S MAIDEN NAME Lucinda Weledry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Mary E. Fishell, Federalsburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> / hr. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>hypertension</i> / sys. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 1956 to <i>Dec. 31</i> , 1956 that I last saw the deceased alive on <i>12/31</i> , 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Anderson</i>		ADDRESS (Street, city, county, state) <i>Federalsburg, Md.</i>	
PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.		DATE SIGNED <i>1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE: <i>Jan. 3, 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Margaret H. Frampton</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 8 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12277  
62

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		12295		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>		c. LENGTH OF STAY IN 1b <i>2 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Isaac Robertson Fleetwood</i>		First	Middle	Last	4. DATE OF DEATH 12	Month	Day	Year 1956	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 22, 1886</i>	9. AGE (in years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Isaac Collier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barking</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Isaac Fleetwood</i>		14. MOTHER'S MAIDEN NAME <i>Amelia J. Fleetwood</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Fleetwood</i>		Address <i>Denton</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Atherosclerosis</i> <i>Coronary Atherosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>medium</i> 3yn -									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Denton</i>	(County) <i>Caroline</i>	(State) <i>Maryland</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dawson D. George</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 12-14-56
EXAMINER'S NAME (Type) <i>Dawson D. George</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 14, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>	22d. LOCATION (City, town, or county) <i>Denton, Md</i>	(State) <i>Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Dawson</i>	ADDRESS <i>111 W. Morelton</i>	24a. REC'D BY REGISTRAR DATE 12-14-56	24b. REGISTRAR'S SIGNATURE <i>Dawson George</i>						

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DEC 17 1956  
BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12278**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 61

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY  Caroline		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Greensboro		c. LENGTH OF STAY IN 1b  2 Wks.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Olean		d. STREET ADDRESS  69 x 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)  Bessie		Fist Middle Last Mae Hopkins	4. DATE OF DEATH 12 28 56 Month Day Year					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1875		9. AGE (In years to nearest birthday) 81 yrs.	10. IF UNDER 1YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife		10b. KIND OF BUSINESS OR INDUSTRY  None		11. BIRTHPLACE (State or foreign country)  Maryland		12. CITIZEN OF WHAT COUNTRY?  U.S.A.		
13. FATHER'S NAME  Alex Gadd		14. MOTHER'S MAIDEN NAME  Ella Jester						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev. Frank Hicks		Address Greensboro, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO  (c)		Myocarditis Acute				INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Bronchitis Chronic				12 mos -		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Dawson O. George		DATE SIGNED  12-28-56		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/56	22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		ADDRESS Greensboro, Md.	24a. REC'D BY REGISTRAR DATE 12/29/56		24b. REGISTRAR'S SIGNATURE L. Mae Poppin			

AMERICAN STATE BOARD OF MEDICAL EXAMINERS  
MEDICAL EXAMINER CERTIFICATE OF DEATH

BUREAU U. S.

MAN 2 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12279

Reg. Dist. No. 66

12297

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rur'l Ridgely		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Gertrudes Academy		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely	
3. NAME OF DECEASED (Type or print) Sister M.		First Placida	Middle Munchmeier
4. DATE OF DEATH 12		Month 12	Day 15
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/1/1869		9. AGE (In years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bararia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Munchmeier		14. MOTHER'S MAIDEN NAME Walburga Mohr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Convent Records Ridgely, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost.		INTERVAL BETWEEN ONSET AND DEATH 5-7 days. GENERALIZED ARTERIOSCLEROTIC HEART DISEASE (b) GENERALIZED ARTERIOSCLEROSIS (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 10, 1956</u> to <u>Dec. 14, 1956</u> , that I last saw the deceased alive on <u>Dec. 14, 1956</u> , and that death occurred at <u>101</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ch. Wm. A. Cott</u> M.D. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <u>Ridgely, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/56	
22c. NAME OF CEMETERY OR CREMATORIUM Saint Gertrudes		22d. LOCATION (City, town, or county) Ridgely, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaes Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE 12/17/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mary E. Laird</u>	

BUREAU V. A.

DEC 19 1956

REG'D V ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12280

12298

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH a. COUNTY Caroline			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 35 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None			d. STREET ADDRESS None					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Mabel	First	Middle Alverta	Last Murray	4. DATE OF DEATH 12	Month 11	Day 19	Year 56	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/12/1921	9. AGE (In years last birthday) 35	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Herbert Potts			14. MOTHER'S MAIDEN NAME Blanche Ewing					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No			16. SOCIAL SECURITY NO. 229-01-0356			17. INFORMANT George Murray, Greensboro, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause (c).  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>			20e. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on Dec. 11, 1956			NOV. 8, 1956 to Dec. 11, 1956			that I last saw the deceased 2:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md.		
ACTUAL SIGNATURE Charles H. Stonesifer			M.D.			DATE SIGNED 12/14/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) B.C.T.			22b. DATE THEREOF 12/15/56			22c. NAME OF CEMETERY OR CREMATORIAL Cokers		
22d. LOCATION (City, town, or county) Greensboro, Md.								
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire			ADDRESS Greensboro, Md.			24a. REC'D BY REGISTRAR DATE 12/15/56		
24b. REGISTRAR'S SIGNATURE L. Max Pippin								

BEREAU V. S.

DEC 21 1971

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filmed 1-14-57 et

12281

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

12299

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Henderson		c. LENGTH OF STAY IN 1b 30 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nora		First	Middle	Last	4. DATE OF DEATH 12 16 1956	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1882	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Patrick Lynch				14. MOTHER'S MAIDEN NAME Henora Miland				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Joseph Mundy		Address Philadelphia, Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO Arteriosclerotic Cardiovascular Disease (c) DUE TO Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ? Intertrochanteric fracture of rt.femur						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home						
20c. TIME OF INJURY Month, Day, Year Hour a.m. Dec. 7, 1956 p.m. at work		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Henderson, Caroline Md.		(County) (State)
21. I certify that I attended the deceased from Dec. 7, 1956, to Dec. 16, 1956, that I last saw the deceased alive on Dec. 16, 1956, and that death occurred at 6:12 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Greensboro, Md.		DATE SIGNED 12/17/56
ACTUAL SIGNATURE Charles H. Stonesifer		M.D.						
PHYSICIAN'S NAME (Type) Charles H. Stonesifer								
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/29/56		22b. DATE THEREOF 12/29/56		22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) Greensboro, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J.S. Boulaire		ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE 12/21/56		24b. REGISTRAR'S SIGNATURE O. Clark Smith		

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURDAU M. S.

DEC 31 1955

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12282

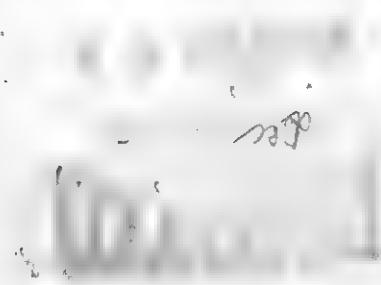
12300

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Roberts	4. DATE OF DEATH 12 24 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary	
13. FATHER'S NAME James Nanai		14. MOTHER'S MAIDEN NAME Elizabeth Vargo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT No		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155X DUE TO Carcinoma of the gallbladder with metastasis to the liver INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c)		Arteriosclerosis, generalized	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 4, 1956, to Dec. 24, 1956, that I last saw the deceased alive on Dec. 23, 1956, and that death occurred at 9:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles H. Stonesifer, M.D. Greensboro, Md. 12/26/56			
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 12/27/56	
22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulous		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR DATE 12/28/56		24b. REGISTRAR'S SIGNATURE Alice Smith	

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 may be made by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12301 CERTIFICATE OF DEATH

12283

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <i>Caroline</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>	c. LENGTH OF STAY IN 1b <i>5 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	d. STREET ADDRESS <i></i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>FREDERICK THOMAS ROE</i>	First <i></i>	Middle <i></i>	Last <i>ROE</i>	4. DATE OF DEATH <i>DEC 14, 1956</i>	Month <i></i>	Day <i></i>	Year <i>1956</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 17, 1868</i>	9. AGE (In years from birthday) <i>88 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. FATHER'S NAME <i>Charles Roe</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca Butler</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Wm Frederick Roe, R.R. 1, Denton, Md.</i>	Address <i></i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i> (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>10 years.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	Day <i></i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>		
21. I certify that I attended the deceased from <i>1948</i> , 19, to <i>Dec 14, 1956</i> , that I last saw the deceased alive on <i>Dec. 13, 1956</i> , and that death occurred at <i>8:30 p.m.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>E. Paul Knotts</i>	ADDRESS (Street, city or town, state) <i>Denton, Md.</i>								
PHYSICIAN'S NAME (Type) <i>E. Paul Knotts M.D.</i>	DATE SIGNED <i></i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 17, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>	22d. LOCATION (City, town, or county) <i>Denton, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Virgil Moore Son Denton, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>12-17-56</i>	24b. REGISTRAR'S SIGNATURE <i>John Virgil Moore Son Denton, Md.</i>						

RECEIVED  
S. A. QVIST

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13105

## 12302 CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg R.F.D.		c. LENGTH OF STAY IN 1b full life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg rural				
3. NAME OF DECEASED (Type or print) Miss Ola Scott		d. STREET ADDRESS none				
4. DATE OF DEATH Dec. 31, 1956		Month Dec.	Day 19			
5. SEX fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1877			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John Scott		14. MOTHER'S MAIDEN NAME Margaret Sullivan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Norris Todd Address Federalburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Parkinson's Disease arterio. & clavini INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Federalburg	(County) Md.	(State)
21. I certify that I attended the deceased from <u>May</u> , 1957, to <u>Dec 31</u> , 1956, that I last saw the deceased alive on <u>Dec 28</u> , 1956, and that death occurred at <u>10P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D. DATE SIGNED <u>Rehoboth Md.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan. 3, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery	22d. LOCATION (City, town, or county) (State) Federalburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Mason</u>		ADDRESS Federalburg, Md.	24a. REC'D BY REGISTRAR Jan 3, 1957	24b. REGISTRAR'S SIGNATURE Everett Nettle, Deputy Registrar		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12303

## CERTIFICATE OF DEATH

12284

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Denton Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
3. NAME OF DECEASED (Type or print) Jerry		d. STREET ADDRESS Denton Road	
4. DATE OF DEATH Turner		Month December	Day 4
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH October 12, 1907		9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months Days
11. BIRTHPLACE (State or foreign country) Southampton Co., Virginia		12. IF UNDER 24 HRS. Hours Min.	13. CITIZEN OF WHAT COUNTRY U.S.A.
14. FATHER'S NAME Robert Turner		15. MOTHER'S MAIDEN NAME Rachel Wiggins	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Lillian Turner, Federalsburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 min acute heart failure 20 hr. auricular tachycardia years Chronic alcoholism	
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		24. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I attended the deceased from 3-21-55, 19, to 12-4-56, 19, that I last saw the deceased alive on 12-4-56, 19, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. Kingsbury PHYSICIAN'S NAME (Type) R. Kingsbury		28. ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED Dec. 7, 1956	
29. BURIAL, CREMATION, REMOVAL (Specify) Burial		30. DATE THEREOF Dec. 9, 1956	
31. NAME OF CEMETERY OR CREMATORIUM Turner's Cemetery		32. LOCATION (City, town, or county) Capron, Virginia (State)	
33. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		34. ADDRESS J. J. Frampton and Son, Federalsburg, Maryland	
35. REC'D BY REGISTRAR DATE Dec. 7, 1956		36. REGISTRAR'S SIGNATURE Margaret H. Frampton	

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DECEMBER 11 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12285  
68

12304

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 10 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillie		First Middle Wilkerson		4. DATE OF DEATH 12 8 1956		Month Day Year			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? 1892		9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Jennie Cain		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT James Wilkerson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Goldsboro		(County) North Carolina	(State) North Carolina
21. I certify that I attended the deceased from 12/18, 1926, to 12/18, 1926, that I last saw the deceased alive on 12/18, 1926, and that death occurred at 9:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) H. F. Silver						ADDRESS (Street, city or town, state) Goldsboro, N.C.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		22d. LOCATION (City, town, or county) Marydel, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais, Greensboro, Md.		ADDRESS J. E. Boulais, Greensboro, Md.		24a. REC'D BY REGISTRAR DATE 12/11/56		24b. REGISTRAR'S SIGNATURE G. Clark Smith			

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